# Referral Form – Domestic Abuse Service

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| CASE INTAKE FORM – Office only |
| Client ID / ref no. | Case worker | Risk level | Repeat? |
|  |  |  | Y / N |

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| Intake date |  | Client aware of referral? |
| **Referrer details**Name/Address/Phone/email |  | Y / NIf no, please advise that the client must choose to engage with SignHealth’s service |
| Involvement with client? |  |

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| Client details | Name/AKA | DOB & age | Gender: |
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| Address | Safe to write? | Alternative address  | Safe to write? |
|  |  Y/N |  | Y / N |
| Email  |  | Safe to email: Yes [ ]  No [ ]  |
| Mobile |  | Safe to text: Yes [ ]  No [ ]  |
| Code word/safe time to contact |  |
| Ethnicity  |  |
| Religion  | Christian [ ]  Sikh [ ] Buddhist [ ]  Other [ ] Hindu [ ]  None [ ] Jewish [ ]  Don’t know/not sure [ ] Muslim [ ]  Would rather not state [ ]  |
| Language(s) spoken  |  | Interpreter required? Y [ ]  N [ ]  |
| Can the client read and write in English? |  |
| Sexual orientation |  |
| Marital Status  | Single [ ]  Married [ ]  Civil Partnership [ ]  Divorced [ ]  Separated [ ]  Widow [ ]  Prefer not to say [ ]  |
| Immigration status and any concerns | British Citizen [ ]  Asylum Seekers [ ]  Refugee [ ]  Spousal Visa [ ]  EEA National [ ]  Other [ ]  |
| Access to Public Funds? | Yes [ ]  No [ ]  |
| What is their housing situation? | Mortgage, private rent, council, sole or joint tenancy?  |
| What is their level of deafness? | Deaf BSL [ ]  | Deaf SSE [ ]  | Deaf Oral [ ]  | Deaf but can’t sign [ ]  | Hard of Hearing [ ]  |
| Any other disability? |  |
| Types of abuse  | Physical [ ]  | Sexual [ ]  | Verbal [ ]  | Financial [ ]   | Emotional [ ]  |
| Describe relationship and living arrangements (eg on/off; client lives at mum’s/(ex) partner stays over occasionally etc) |  |
| Drug / alcohol / mental health issues / diagnosis treatment |  |
| Describe employment (eg occupation / unemployed / in training or education / financial status / benefits). Include addresses & contacts) |  |
| Is the client experiencing domestic abuse now? | Y/NIf no, does the client need emotional support or want to join a survivor group? |
| Does the referrer assess that the client could pose a risk to SignHealth staff? Y □ N □ |
| If yes, consider steps that need to be taken/can support safety be offered? |
| Any agencies involved with the client now? |
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| Does the client feel they are safe now? | Y [ ]  N [ ]  |
| Do they feel the children are safe? | Y [ ]  N [ ]  |
| Does they have somewhere to stay if they need to leave?e.g family, friends  | Y [ ]  N [ ]  |
| Are they aware of access to safe refuge? | Y [ ]  N [ ]  |

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| **Partner / ex-partner / family member details** | Name/AKA | DOB & age | Gender |
|  |  | M / F |
| Address | Drug / alcohol / mental health issues / diagnosis / treatment |
| No fixed addresses. Living with client – Y [ ]  / N [ ]  |  |
| Has this person had involvement with police? Are there a restraining order?  |
| Ethnicity |  |  |
| Religion |  |
| Languages spoken |  |
| Physical description of perpetrator: |
| Deaf or Hearing? | Deaf: [ ] Hearing: [ ]  |
| Height :Build :Hair colour:Distinguishing features : |
| Immigration issues and any concerns |  |

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| **Children’s details** | Gender | DOB / age | Deaf /Hearing | Is (ex-)partner parent of child / unborn baby? (if not, state who parent is) | Does (ex) partner have PR? | School |
| Name | M / F |  | D / H |  | Y / N |  |
| Name | M / F |  | D / H |  | Y / N |  |
| Name | M / F |  | D / H |  | Y / N |  |
| Is the client pregnant? |  Y [ ]  N [ ]  | Due date |  |
| Living arrangements and address (if different to client details above) |  |
| CYPS involvement |  Y [ ]  N [ ]  |  |
| Describe involvement (Flag significant concerns regarding children. Any issues with child contact?) |  |

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| SIGNIFICANT CONCERNS FLAG (eg staff safety issues / serial or repeat perpetrator /suitable times to call client / HBV / suicide or self-harm concerns / MARAC case) |
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| Reason for referral / details of incident prompting referral / history of relationship, including police call outs / A & E attendances / injuries / children witnessing |
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| What does the client hope to receive from SignHealth services? |
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| **Office only** |
| **Checklist** | SafeLives Dash risk checklist completed | Y / N |
| Referred to MARAC | Y / N |
| ISSP in place | Y / N |
| Confidentiality and information sharing agreement consented to by client | Y / N  |
| Service explanation provided | Y / N |
| Monitoring and evaluation of data consented to by client | Y / N  |
| Is there a conflict of interest in this case? | Y / NIf yes, discuss with your manager |
| **Other** |  |

PLEASE NOTE COMPLETED REFERRAL TO BE SENT TO THE FOLLOWING ADDRESS da@signhealth.org.uk